STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	This visit was for a State licensure survey. Facility #: 005108 Survey Dates: 05-31-11/06-01-11 Surveyors: Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor Ken Zeigler Laboratorian QA: claughlin 06/06/11	S0000	Thank you for the opportunity to be one of the first facilities to use the online submission process.	
S0406	410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview,	S0406	Direct Service of PediatricsThe	06/14/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the facility failed to ensure one (1) direct service and four (4) services provided by contract were included in the facility Quality Assurance and Performance Improvement (QAPI) program. Findings include: 1. Review of facility documents on 6-1-11 indiccated lack of evidence that the direct service of pediatrics and the contracted services of transcription, ambulance service, laundry/linen and mobile cataract services were included in the facility QAPI program. 2. Interview with #S3 on 6-1-11 at 1245 hours confirmed the direct service of pediatrics and the contracted services of transcription, ambulance service, laundry/linen and mobile cataract services were not included in the facility QAPI program.		deficiency was corrected on 6/14/11 with discussion at the Quality Council meeting. A pediatric quality indicator review form was developed to be utilized in the review of 100% of all pediatric cases. Any pediatric cases that do not meet quality criteria as set forth; they will be referred to the appropriate Medical Staff representative for further review and follow up action as necessary. The final form along with any follow up documentation will be submitted to Quality Review quarterly. This will become part of the master quality spreadsheet and will be monitored on an ongoing basis. The information will also be shared with the Patient Area Care Committee, Patient Safety/Quality Council, Department Manager Meeting, Medical Staff and the Board of Directors. The MedSurg Nurse Manager or designee will be responsible for monitoring the pediatric quality indicator review form on every pediatric case. Transcription Contracted ServicesThe deficiency was corrected on 6/14/11 with discussion at the Quality Council meeting. Quality assurance scores were sent to St. Vincent Jennings Hospital by the Manager of Transcription at St. Vincent Health. The quality assurance scores will be run on a quarterly basis and sent to the Health Information Management department. A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			reminder notice will be sent to the Manager of Transcription at St. Vincent Health prior to quarter end on an ongoing basis. Revenue Cycle Operations Manager or designee will be responsible for ensuring the quality assurance scores are received and forwarded on to the quality council on a quarterly basis. Ambulance ServiceThe deficiency was corrected on 6/14/11 with discussion at the Quality Council meeting. Reviews on the ambulance service have been performed on an ongoing basis but have not been reported to the quality council for inclusion in the master quality spreadsheet. Ambulance service has now been added to the quality spreadsheet to be shared with the Patient Area Care Committee, Patient Safety/Quality Council, Department Manager Meeting, Medical Staff and the Board of Directors. The information has now been made a part of this reporting mechanism and will be reported from this point forward. The Emergency Department Nurse Manager or designee will report the ambulance service reviews to quality council. Laundry/Linen ServiceThe deficiency was corrected on 6/14/11 with discussion at the Quality Council meeting. The linen delivery and quality checklist was being completed and turned into the quality review on a quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			basis; however, the information was not reported on the quality spreadsheet that is shared with the Patient Area Care Committee, Patient Safety/Quality Council, Department Manager Meeting, Medical Staff and the Board of Directors. The information has now been made a part of this reporting mechanism and will be reported from this point forward. The Housekeeping Supervisor or designee will report the linen delivery and quality checklist to quality council on an ongoing basis.Mobile Cataract ServiceThe deficiency was corrected on 6/14/11 with discussion at the Quality Council meeting. It was determined that per the contractual obligations of SightPath, mobile cataract service, that St. Vincent Jennings Hospital surgery staff will monitor SightPaths' ability to provide all of the items needed to provide cataract surgery. A checklist will be provided to surgery staff for them to inventory the presence of all equipment as needed to provide cataract services. SightPath has been added to the quality spreadsheet and will be collected and monitored on an ongoing basis. The information will then be reported to the Patient Area Care Committee, Patient Safety/Quality Council, Department Manager Meeting, Medical Staff and the Board of Directors on an ongoing basis. The Surgery Manager or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			designee will report the checklist to quality council on a quarterly basis.	
S0932	410 IAC 15-1.5-6 (b)(4) (b) The nursing service shall have the following: (4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. Based on document review and staff interview, the facility failed to develop an individualized care plan for 1 of 4 in-patients. Findings include: 1. Review of patient #N17 medical record beginning at 11:30 a.m. on 6/1/11 indicated the following: (A) The patient had only one (1) problem addressed in his/her careplan. The careplan developed indicated the patient required oxygen. (B) The oxygen was discontinued on 5/29/11. Care plan did not reflect oxygen was discontinued.	S0932	The deficiency will be corrected on 6/30/11 by the completion of mandatory training for all nurses on the appropriate way to implement care plans in Quest. This training will take place on June 28th and June 30th. Chart audits will be done on a monthly basis with reporting to quality council quarterly on an ongoing basis. MedSurg Nurse Manager or designee will be responsible for the chart audits and reporting to the quality council.	06/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0952	410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). **Based on record/policy review and staff interview, the hospital failed to ensure administration of blood transfusions in accordance with approved medical staff policies and procedure for six of eight patients.** **Findings include:** **1. The policy "Transfusion of Packed Red Blood Cells", revised 6/02, read:** **"Vital signs (complete) are then taken every 15 minutes x's 2 then every 30 minutes until blood in (sic) infused and at the completion of the transfusion. Post-Transfusion vital signs are taken at 60 min -/+ 10 minutes.**	S0952	This deficiency will be corrected on 6/30/11. A policy and procedure revision was completed. Initiation of new blood bank documentation form was completed. A mandatory training for all nurses on June 28th and June 30th will be done to educate the nurses as to the revised policy and new documentation form. An audit of 100% of all blood transfusions will be done on a weekly basis with submission to quality council on a quarterly basis. The audits will be completed on an ongoing basis. Audit report by the Laboratory with any deficiencies documentation will be reported to the Nurse Manager or designee for follow up corrective action. The corrective action report shall be returned to the Laboratory within 10 days of notification of the Nurse Manager or designee. The Laboratory Supervisor or designee will be responsible for maintaining compliance.	06/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Vital signs may be taken more often per nursing judgement and patient status. Vital signs are to be recorded on the transfusion record sheet." **2. In review of six patients receiving twelve blood units, six of these received-units did not have complete documentation, per policy, on the Transfusion Record Sheet form including:** **Patient #1** **--Unit #1 administered on 5/29/11 at 2225: The 1 hour post vitals were documented at 5 minutes.** **Patient #2** **--Unit #2 administered on 5/03/11 at 1245: There was no temperature documentation for the 1 hour post transfusion vitals.** **Patient #3** **--Unit #3 administered on 4/30/11 at 1810: The 1 hour post transfusion vitals were documented at 10 minutes.**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Patient #6: **--Unit #4 administered on 3/18/11 at 1515: There was no transfusion stop date/time; there were no post-transfusion vital time or vitals** **Patient #7:** **--Unit #5 administered on 3/15/11 at 1340: There was no documentation of who entered the vital signs for the post transfusion.** **Patient #8:** **--Unit #6 administered on 2/28/11 at 1450: There was no documentation of who entered the transfusion stop date and time.** **3. On 5/31/11 at 1:00 p.m., staff member #10 acknowledged the above-listed missing documentation.**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation, document review and interview, the facility created conditions which could result in a hazard to patients, visitors and staff in 2 instances. Findings include: 1. While touring the radiology department on 5-31-11 at 1310 hours with #S2, #S13, and #S4, it was observed that the eye wash station in the dark room where caustic chemicals are used lacked documentation of testing the eye wash to ensure it works properly, thus creating a potential safety hazard. 2. While touring the facility on 5-31-11 at 1330 hours with #S2 and #S13, it was observed that there was no available eye wash in the area where caustic chemicals are used for water testing, thus creating a potential safety hazard. 3. Review of facility documents on	S1118	The deficiencies were corrected on 6/3/11. Plant Operations has provided the Radiology Manager with a checklist and procedure sheet that is posted beside the eye wash station in the dark room. Eye wash checklist will be completed weekly by Radiology staff. Reporting will be submitted to quality council quarterly. The Radiology Manager or designee will be responsible for the ongoing review and monitoring in the department with quarterly submissions to quality council. Eye wash station for mechanical room water testing area was ordered and installed on 6/3/11. A checklist was posted by the eye wash station. A bottle with the appropriate solution is marked with the expiration date and is kept by the eye wash station. All Plant Operations staff were educated on 6/3/11 on the proper use of the station and the solution. A check of the eye wash station was added to the mechanical room walk through	06/03/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5-31-11 indicated lack of evidence of eye wash testing in the radiology dark room. 4. Interviews with #S2 and #S13 on 5-31-11 at 1310 hours and 1330 hours respectively confirmed the lack of documentation of eye wash testing in the radiology department dark room and the lack of an eye wash in the area where water testing is done and that caustic chemicals are used in both areas.		inspection list that is completed daily. The Plant Operations Manager or designee is responsible for submission to quality council quarterly on an ongoing basis.	
S1162	410 IAC 15-1.5-8(d)(2)(A) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule. **Based upon document review and staff interview, the laboratory failed to ensure documentation of preventative maintenance of required rotations per minute (rpm) testing or time checks for one of five centrifuges used in routine chemistry (urinalysis), in**	S1162	This deficiency was corrected on 6/6/11.The Prothrombin Time policy/procedure has been revised to include appropriate RPM and spin times necessary to achieve platelet poor plasma acceptable for testing. The RPM and spin times will be checked annually by the Laboratory Supervisor or designee on an ongoing basis. Documentation of annual testing will be maintained	06/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accordance between the approved policies and procedures, and clinical engineering reported. **Findings included:** **1. The policy "Prothrombin time (PT), policy/procedure # COAG 001.02, revised 2/14/07, used for testing PT values lacked documentation to indicate either the rotations per minute (rpm) or total spin times for this test.** **2. Review of the clinical engineering work order performed on 5/05/11 for the Plasemafuge-6, serial #61060-16, used to centrifuge PT specimens, indicated this centrifuge was checked for 3700 rpm (actual 3700) and timer 15 minutes (actual 15 minutes). It could not be determined these values were within acceptable limits.** **3. On 6/01/11 at 11:00 a.m., staff member # 15 acknowledged the above-listed missing**		in the Laboratory.This deficiency was corrected on 6/6/11.The testing of platelet poor plasma per policy/procedure was completed at 3700 RPM at 15 minutes and yielded appropriate platelet-poor plasma. This will be checked annually by the Laboratory Supervisor or designee on an ongoing basis. Documentation of test results will be maintained in the Laboratory.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation.			
S1166	410 IAC 15-1.5-8(d)(2)(C) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (C) Appropriate records shall be kept pertaining to equipment maintenance, repairs, and current leakage checks. Based upon document review and staff interview, the laboratory failed to assure blood bank alarm temperature wheels were properly maintained and in working order for three of three quarters between 2010 and 2011. Findings included: 1. The policy "Alarm Testing", file name: 1.235, revised 1/15/07, read: "Blood Bank Refrigerator Quarterly Alarm Checks Year: Requirement: Perform alarm	S1166	This deficiency was corrected on 6/13/11.Blood Bank alarm check placed on a computerized notification schedule for quarterly testing. Lab Tech will do alarm check and document quarterly on an on-going basis. Documentation will be kept by the Laboratory. The Laboratory Manager or designee will be responsible for compliance.	06/13/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	checks according to SOP #1.235" 2. Quarterly certification tests for the refrigerator used for blood unit storage indicated quarterly checks were to be documented on 11/12/10 and 3/03/11. Review of the quarterly documentation indicated: Last Run Date Quarterly date due Actual Date Late 8/12/10 11/12/10 12/03/10 20 days 12/03/10 3/03/10 5/26/11 2 months, 23 days Each of these above-listed dates were not within the quarterly dates required per policy. 3. On 6/01/11 at 10:00 a.m., staff member #15 acknowledged the above-listed missing documentation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151303	A. BUILDING 00 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE